

Authors

Arturo Álvarez Rosete  
Roberto Nuño-Solinís

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**A system-wide transformation towards *integrated chronic care*. The Strategy to tackle the challenge of chronicity in the Basque Country.**

## 1. Introduction

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How do you instil system-wide changes in health and social care? This is the ultimate question that this paper aims to shed light upon. Are there any lessons to learn from those brave few which have eventually tried?

In July 2010, the regional government of the Basque Country launched the *Strategy to tackle the challenge of chronicity in the Basque Country* with the declared aim to transform the Basque health system in the medium term, to make it fit for the purpose of responding to the challenge of chronicity. The Strategy has been revolutionary in many ways, not only within Spain<sup>1</sup> but also outside, and, as a token of its transformative capacity, it has actually been endorsed by the new regional government that emanated from the regional elections later on.

The *Strategy* has been described and analysed in various publications and preliminary evaluations of results undertaken already<sup>1-4</sup>. Differently to these previous contributions though, the purpose of this study is to provide a policy-oriented analysis of the *Strategy to tackle the challenge of chronicity in the Basque Country*, from three distinctive analytical angles: health policy (integrated care), organisational theory and policy analysis. This multi-dimensional look helps to raise a number of key questions that may not necessarily spring to the researcher's mind in the first place, but which help to understand why and how such a system-wide integrated care transformative process eventually happened.

## 2. Scope of this study and methodology

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There are no simple and direct answers to the question of how to instil system-wide changes in health and social care. At least, this paper does not aim to provide one. Instead, this paper has been written to provoke questions rather than to provide answers.

The primary purpose of this paper is to become a useful resource for teaching at the academic modules of the Deusto Business School Health. It engages with three different social science disciplines (health policy, organisational theory and policy analysis) to selectively choose some of the recurrent issues that these different literatures ask. Ultimately, the aim is to provoke students to question themselves as much as to provide them with conceptual and analytical tools that might help them find their own answers.

Research techniques used in this study include documentary analysis and semi-structured interviews. Documentary analysis has been used to gather data on the content of the Basque policy reform, the way it has been implemented and the preliminary achievements. Documents reviewed include government reports, official statistics, memos, articles in specialist literature, etc. Semi-structured interviews have been used to reconstruct the process of designing and implementing the strategy. Twelve interviews were conducted in September and October 2015 and informants included former and current top officials at the Basque health department, health managers, doctors and nurses of public health provider Osakidetza. Whenever informants agreed to, these interviews were recorded and transcribed for detailed narrative and thematic analysis.

### 3. Background

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Located in the north of Spain and extending over 7,000km<sup>2</sup>, the Basque country is the 7<sup>th</sup> (out of 17) largest autonomous community of Spain in terms of population (more than 2 million people) and, together with neighbouring Navarra and Madrid, with a GDP per capita above the European mean.

The Basque public health system is a single-payer national health system offering universal coverage for all residents and mainly financed through taxation. The Department of Health and Consumer Affairs of the Basque Government is responsible for policy making, for public health and for planning and financing health care. In turn, Osakidetza is the only public provider of health services in the region, including primary care, hospital care (both acute and long-term care), specialist outpatient clinics, emergencies and mental health.

Similarly to what occurs in the rest of Spain, chronicity represents the biggest challenge to the sustainability of the Basque health system. At present, 38% of the Basque population has at least one chronic condition and it has been estimated that, by 2040, the number of chronic patients older than 65 years will double. Chronic conditions currently cause 80% of the interactions with the Basque health system, which results in accounting for 77% of total health expenditure. Specifically, treating chronic conditions cause 58% of primary care visits and 75% of drug prescriptions.

Contemporary health systems are not ready to respond to the challenge of chronicity. The Basque public health system, like the other regional health services in Spain and worldwide, has been designed as a reactive, curative system to respond to acute episodes.

Obviously, these tensions become much more visible during bad economic cycles. After years of real GDP growth above the EU average due to fiscal surpluses and declining unemployment, the Spanish economy deteriorated rapidly in 2008–2009 entering a profound recession, with real GDP falling drastically in 2009 by -3.6% and unemployment rate rising from 8.5% in 2007 to 18.6% in 2009. A local economic crisis predated the global one and actually exacerbating its effects. By 2010, the risk of a financial bailout of the Spanish economy was felt quite possible.

Tough cost-containment decisions, tax increases and other measures aimed to bring down the public sector deficit and achieve savings were announced and undertaken at all government levels (national and regional). It is within this extremely difficult context of economic crisis that the new elected regional government of the Basque Country simultaneously took cost-containment measures and the decision to undertake a process of system-wide transformation of the public health system. The two-sided policy agenda implied that, on the one side, key tensions of the health care organisation in such a constrained economic scenario (i.e. waiting lists, budget management, human resource management, etc.) had to be dealt with. However, the other side of the policy agenda acknowledged that even if these crisis decisions were handled in an effective way, they would not be able to cope with the future challenges of demography, chronicity, fragmentation and sustainability. Thus, looking above and beyond the immediate urgencies and short-run constraints, in July 2010 the Department of Health and Consumer Affairs of the Basque Government launched the *Strategy for Tackling the Challenge of Chronicity in the Basque Country*<sup>2,5</sup>.

## 4. Key elements of the Strategy

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This section describes the content of the Basque Strategy and the process it was formulated and implemented. Thus, it starts by presenting the vision the Strategy pursues and the theoretical frameworks that sustain, followed by the strategic interventions by which the vision is accomplished. The third sub-section describes the way the Strategy was formulated and implemented.

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### 4.1. Vision

The *Strategy to tackle the challenge of chronicity in the Basque Country* aims to respond to the needs generated by the phenomena of chronicity to both chronic patients and their carers (offering them a more integrated and continued care, adapted to their needs), health workers (allowing them to devote more time to work on issues of higher added value and having access to the necessary tools), and citizens (as tax payers by a more efficient use of the existing systems resources and as potential chronic patients by supporting them in prevent the development of chronic conditions and to promote their own health).

The Strategy is divided into 5 areas, which reveal the core elements of the model of care for tackling chronicity:

- A population health approach
- Prevention of chronic illnesses
- Patient responsibility and autonomy
- Continuity of care
- Efficient interventions adapted to the need of the chronic patient

This vision is embedded upon a number of contemporary theoretical frameworks that are worth identifying and exploring in detail. Chronicity is the key term that provides the compelling narrative for reforming the health system in the Basque country. Following Nolte and McKee, “the goals of chronic care are not to cure but to enhance functional status, minimize distressing symptoms, prolong life through secondary prevention and enhance quality of life”<sup>6</sup>.

The buzzword of the Strategy is chronicity. The epidemiological transition towards chronic illness that the Basque Country is experiencing is identified as a “challenge” to the health system. So the purpose is to bring raise the profile of chronicity and bring it to the policy agenda – “raise chronicity to the policy level”<sup>4</sup>.

It is worth noting that the focus is not “chronic diseases” but “chronicity, as a phenomena, or “chronic patients”, as primary recipients of the intervention: the Strategy is not a compilation of recipes to deal with diabetes, COPD or other chronic diseases, but a system-wide, population-based response to a challenge that cross-cuts care boundaries, health and social care sectors and public and private spheres.

The Basque Strategy is strongly underpinned by the Chronic Care Model<sup>7-8</sup> (CCM) developed by Ed Wagner and colleagues of the MacColl Institute for Healthcare Innovation in Seattle (USA). Rather than a list of solutions and interventions, the CCM is a framework to conceptualise the concurrence of complex interventions at various levels and in various sectors: a) the entire society, bringing together the multiple public and private resources; b) the health system, in all its essential dimensions of funding mechanisms, regulatory schemes, delivery organisations, etc.; c) the service-level, where clinical decisions are made and patient exercises its decision making and autonomy capacity.

The system approach is important in the Basque Strategy. It implies that facing the challenge of chronicity cannot be tackled by making incremental adjustments to existing services and ways of working. Instead, a step-change is needed, affecting the whole system:

The Strategy aims to be a new way of organizing the service delivery, to impact in all dimensions of the system (health results, satisfaction, quality of life of the patient and carers, sustainability). Similarly, this structural transformation goes beyond the current economic situation, requiring a long period (at least from 2 to 5 years) before showing a substantial impact in the system<sup>2</sup>.

Subtler than the concept of system in the Basque Strategy appears the “Triple-Aim” framework<sup>9</sup>. According to this framework, high-value health care can only be achieved if “improvement initiatives pursue a broader system of linked goals. In the aggregate, we call those goals the “Triple Aim”: improving the individual experience of care; improving the

health of populations; and reducing the per capita costs of care for populations”. The framework was later used to evaluate the contributions of the Strategy.

#### 4.2. Interventions

The Strategy is a plan, and decision makers decided not to develop regulatory or legislative instruments in the first instance<sup>4</sup>. Instead, they aimed to develop a combination of top-down and bottom-up change levers – indeed, the 14 Strategic Projects (see Figure “Aligned Management Processes as Integrators”). These areas were developed through the 14 “strategic projects” listed in table 1 below.

Table 1. The 14 Strategic Projects within the Basque Chronic Illness Strategy

Population health management	Prevention and promotion	Patient autonomy	Continuity of care	Adapted interventions
1. Stratification and targeting of the population	2. Interventions aimed at tackling the principal risk factors	3. Self-management education: Active Patient – Paziente Bizia programme 4. Setting up a network of active patients, connected through the adoption of web 2.0 technologies	5. Integrated EHR (electronic health record) 6. Integrated care 7. Development of sub-acute hospitals 8. Advanced nursing competencies 9. Collaboration between providers of social and health care (development of a sociohealth collaborative framework with social services) 10. Funding and contracting	11. OSAREAN: multi-channel centre (coordinating the provision of e-health services, health advice, and non-face-to face appointments, among other activities). 12. e-prescription 13. Creation of KRONIKGUNE: chronicity health services research centre
14. Bottom-up innovation projects				

Source: Nuño-Solinís R, Vázquez Pérez P, Toro Polanco N and Hernández-Quevedo C (2013) Integrated Care: The Basque Perspective, International Journal of Healthcare Management, vol. 35, issue 3, pp. 167-73.

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### 4.3. Process

The processes of formulating and implementing the Strategy for Tackling the Challenge of Chronicity in the Basque Country were quite innovative as well, certainly departing from the usual dynamics of the Spanish public administration. Policy makers were quite aware that such system-wide transformation would require time, effort, leadership, vision and commitment, as well as a shared narrative, inclusiveness, interaction with local implementers, “muddling through” and constant learning. Hence, the usual command-and-control approach to formulating and implementing health policies was replaced by a consensual, collaborative and far “messier” process<sup>10</sup>. Underlying the Strategy, there is an understanding of the limits to the capacity of government to lead such transformative initiatives alone and the need, instead, to “develop favourable policy environments”, “stimulating” new ways of thinking, carry out “joint” initiatives and “encouraging a distributed leadership approach”<sup>4</sup>. Actually, in parallel to the work conducted to formulate the Strategy, working groups with health staff to work on different areas (chronic diseases, acute treatment of chronic conditions, etc.) were set up in different areas, which helped to prepare the momentum for the Strategy [interview 5].

From the start, there has been an attempt to sustain the reform with sound evidence of what was working. In order to support the production, compilation and dissemination of evidence, a number of institutes or bodies were set up or brought into a new focus. Etorbizi was launched as a promoter of innovations in health and social care. Kronigune was set up to research on health services for chronicity and facilitate the dissemination of innovative models of care. In addition, two bodies were set up and became key agents for change: (i) O+berri, the innovation institute that designed the Strategy, promoted innovation projects and was responsible for launching 50% of the 14 projects; and (ii) the Chronic Care Office (*Oficina de la Cronicidad, OEC*), responsible for the monitoring of the strategic projects. Each project was managed by a team, under the lead of a project leader.

## 5. Achieving results

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If the ultimate test of any system-wide project is that things start changing on the ground, already in 2012, the Basque Health Department confirmed that the system had started to move towards a proactive, more efficient and better integrated health system, thanks to the strategic projects already implemented and the different pilots and projects launched<sup>3</sup>. Nuño-Solinis et al.<sup>1</sup> also confirmed that the transformation of the Basque health system “was on the right track”.

Over the two years after the launch of the Basque Strategy in 2010, a key element that gradually gained prominence in the narrative for change was the need to pursue transformations at “local micro-systems” [in Spanish, *microsistemas locales*]. Such transformations were envisaged either virtually (in the form of networks of providers) or structurally (in the form of new organisations). While structural transformations were not directly encouraged, these were rolling out gradually. Thus, new integrated care organisations (inspired by Shortell’s Integrated Delivery Systems<sup>11</sup>) [in Spanish *Organizaciones Sanitarias Integradas*, OSIs] gradually emerged as one option to managing the provision of the health care continuum. OSIs are a group of provider organisations (commonly a regional hospital and the primary care centres that refer patients to it) that takes responsibility for providing all care for a given population within a territory, for a defined period of time under a contractual arrangement with a health authority. Each OSI develops its own integrated strategic plan, which includes common goals for both primary and secondary care and specifies the single source of funding. Following, each OSI promotes the setting up of technical boards and mixed clinical committees to facilitate mutual knowledge and exchange of communications between primary and hospital care staff. The purpose of such vertical integration was to harmonize and achieve savings in human resources and financial management, as well as the development of common strategies and plans<sup>12</sup>. The first OSI-type experience was the Red de Salud Mental de Bizkaia in mental health, set up in 2010, although the first proper OSI was Bidasoa in 2011. This was followed a year later by 3 more: the OSI Alto Deba, the OSI Bajo Deba and the OSI Goierri-Alto Urola. Initially, vertical integration of organisations was avoided and, instead, it was sought “virtual” organisational integration through contractual arrangements without real risk transferring. As it will be pointed below; this is one of the differentiating elements with the post-2013 phase.

What was the level of achievement of the 14 strategic projects by the time the political leadership changed in 2013? Below, a brief summary is only provided, as a more extended analysis is provided elsewhere<sup>13</sup>.

- SP1: Stratification of the entire Basque population according to the risk of hospitalization and targeting of those people at most risk. With the 100% population stratified, this is one of the projects that advanced most.
- SP2: Aims to construct a common framework for the prevention and promotion interventions concerning the principal risk factors related to chronic illnesses. Over these years, good public health experiences have been implemented in the Basque Country but “these haven’t been up-taken by the organisation as a whole and they won’t be remembered as an inheritance from the Strategy” [interview1]. Anyway the previous screening programmes (breast cancer and colorectal cancer) were strengthened, having the Basque Country the highest coverage of all Spanish Regions.
- SP3: Self-management education: Active Patient – Paziente Bizia programme, which adapted the “Chronic disease Self-Management Program” developed by the University of Stanford. Over the period of implementing the Strategy, more than 1000 patients have been trained.
- SP4: Setting up a network of active patients, connected through the adoption of web 2.0 technologies in order to improve access to information and to promote interaction and mutual support between members. As a key achievement, the platform Kronikoen Sarea was launched.
- SP5: Integrated electronic health record to facilitate the access to data and to support decision-making. The Shared Electronic Health Record (Osabide Global) was fully implemented by 2014.
- SP6. Integrated care: promoting innovative models for the continuity of care between primary and specialised care. There have been important advancements in this area.

- SP7. Development of sub-acute hospitals as an intermediate level of care between the conventional hospital for acute patients and traditional primary care centres (thus, a lower level of concentration of technology and resources than the hospital but a more specialised resolution capacity than primary care). This strategic project was little developed though.
- SP8. Definition and development of advanced nursing competencies focussed on chronic care. As a result, case managers and liaison nurses roles have been defined.
- SP9. Collaboration between providers of social and health care (development of a sociohealth collaborative framework with social services). There has been little improvement in this area, beyond a few local experiences.
- SP10. Funding and contracting. New commissioning were developed to influence the system-wide transformation moving progressively from an activity strategy to an adjusted population and health results strategy. In 2012, the Contract-Programme, the instrument that sets the objectives, budget and evaluation system for provider organisations, has linked 3% of the budget for the public sector providers that are located in the same area and are responsible for the same population to the achievement of several pro-integration objectives.
- SP11: OSAREAN: multi-channel centre (coordinating the provision of e-health services, health advice, and non-face-to-face appointments, among other activities) “to increase the number of ways in which the public can interact with the health system”. Many interviewees pointed to the holding of remote consultations between primary care and hospital specialist doctors as one of the key areas of advancement [i.e. interview 1]. However, the development of the multi-channel centre required important economic investment.
- SP12: e-prescription, bringing safety and savings to drug dispensation and administration by creating a single electronic pharmaco-therapeutic record of the patient encompassing all care levels. This project has been fully implemented.
- SP13: Creation of Centre of Research for Chronicity to identify, adapt, pilot, and introduce the best practices to deal with the challenge of chronicity, generating

“glocal” knowledge for innovation in organisation and management and to improve the health systems.

- SP14: Bottom-up innovation projects. “During the 3 years since the publication of the Strategy, more than 150 bottom-up initiatives have been launched as a result of local experimentation and through the creation of conditions for people on the ground to identify the best solutions. Notably, two thirds of these initiatives are related to clinical integration”. As a result, some new models have emerged (i.e. the role of the internist of reference).

Evidence of positive achievements has been gradually mounting since the launch of all these initiatives as part of the Strategy. Evaluations of the effects of the implementation of the Basque Strategy commenced very early since its launching, with the development of evaluative tools that sought to track progress in care for chronic illness (such as IEMAC/ARCHO) and for assessing outcomes (at both patients and population levels)<sup>14</sup>.

Toro et al.<sup>12</sup> measured the “organisational readiness for chronicity” in the Bidasoa OSI and found improvements in patients’ perceptions of care coordination, reductions of hospital utilisation and cost-containment in terms of per capita expenditure. Table 2 below provides an overview of the most relevant achievements of the Bidasoa OSI in terms of improved patient experience.

Table 2. Patient care experience: an overview

Dimension	Indicators
(2.A) Experience of care: patient satisfaction survey timeline: one survey in 2013	86% considered good/very good, coordination between primary and secondary care as a result of structural integration 66% considered good/very good, coordination between health and social care as a result of structural integration
(2.B) Experience of care: hospital utilisation timeline: 2009–2013	Reduction in hospital admissions: 7% Reduction in hospital readmissions: 24% Reduction in A&E admissions: 16%
(2.C) Coordination between primary and secondary care timeline: 2010–2013	Reduction in Ambulatory Care Sensitive Conditions: 10%
(2.D) Patients with complex or multiple conditions timeline: 2011–2013	Reduction in hospital admissions: 38% Reduction in A&E admissions: 31%

Source: Toro Polanco N, Berraondo Zabalegui I, Pérez Irazusta I, Nuño Solinís R and Del Río Cámara M (2015) Building integrated care systems: a case study of Bidasoa Integrated Health Organisation, *International Journal of Integrated Care*, vol. 15.

Likewise, the Red de Salud Mental de Bizkaia has managed to increase community care for mental health patients and reduce hospital stays in psychiatric wards. Hospital returns within 30 days after discharge fell by 55% in just two years (from 16% in 2012 to 7% in 2013)<sup>15</sup>.

## 6. Analysis

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In this section, a kaleidoscopic strategy approaching the issue from three different disciplines – health policy, organisational theory and political science – is applied to allow us to ask interesting research questions to analyse the Basque Strategy.

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### 6.1. Transforming systems, focusing on services

Within the broad health policy discipline, the fields of integrated care and chronic care have been converging in arguing that contemporary health systems are not fit for facing the complex needs of the population and so greater coordination/integration of levels of care, services and health and social care is needed<sup>16</sup>. Furthermore, both literatures coincide in implying that the required changes cannot be tackled by making incremental adjustments to existing services and current ways of working. To give just one example, although case management has now become a key and popular component of integrated care and chronic care reforms around the world, “the policy on its own is unlikely to reduce hospital admissions in the absence of a more radical system redesign”<sup>6</sup>. Thus, there is a need to “fundamentally challenging the current and future design of care systems”<sup>17</sup>, to take a step-change to transform systems<sup>10</sup>.

There is a rich two decade-long thinking of the concept of health system since the publication of the WHO 2000 Report. The WHR 2000 report took a broad view of health systems as including: “all the organisations, institutions and resources that are devoted to producing health actions (...) A health action is defined as any effort, whether in personal health care, public health services or through inter-sectoral initiatives, whose primary purpose is to improve health”<sup>18</sup>. According to WHR 2000, all health systems pursue the same three goals (improving the health of the population they serve; responding to people’s expectations; providing financial protection against the costs of ill-health) which are sought through four health system functions (service provision; resource generation; financing; stewardship).

Since the publication of the WHR 2000, the concept of health system has been established firmly within the health policy literature<sup>19</sup>, underpinning current debates on health system financing, performance measurement, universal health coverage, stewardship, etc.

Recently, discussions have led to the refinement of the WHR 2000 original framework, “in order to operationalise it...to clarify areas of ambiguity, such as those related to boundaries, and (to) expand upon it by filling in some of the spaces between broad goals and functions”<sup>20</sup>.

A key consequence of this whole collective effort to conceptualize health systems has been the gradual bringing of the service delivery function back in – arguably somehow buried under the dominance of debates worldwide concentrating on other system functions and issues, mostly debates about health care financing (collection and pooling of funds, purchasing of services), managerial processes (quality systems), measuring health system performance, health human resources, stewardship and regulation, etc. Both the chronic care and the integrated care literatures locate service delivery right at the centre of the discussion. Indeed, the recently launched *WHO global strategy on people-centred and integrated health services* shows such recovery of the centrality of the service delivery function – arguing that the WHO desire to move towards universal health coverage “will not be achieved without improvements in service delivery so that all people are able to access high quality health services that meet their needs and expectations”<sup>21</sup>.

Shaw and colleagues’ definition of integrated care puts the emphasis on the delivery of services, concentrating actions and interventions towards the act of caring: “it is an organizing principle for care delivery with the aim of achieving improved patient care through better coordination of services provided”<sup>22</sup>. Integration, on the other hand, - as a “coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors”<sup>23</sup> - becomes then instrumental to achieving this aim. In other words, interventions on the other functions need to serve the purpose of providing services according to the organizing principle of integrated care. A single (but interconnected) act of providing care constitutes the ultimate target of this mobilization of inputs, functions, organisations and people. The ensemble of organisations, institutions and resources get activated, to ultimately meet the needs of a person or persons through the provision of certain services.

This (selective) look from the twined integrated care and chronic care literatures lead us to the following two key questions:

- ✓ Is such a whole-system change possible?

- ✓ What does imply to bring service delivery function at the centre?

As the Basque Strategy is underpinned by this system-wide thinking, its analysis becomes extremely interesting to shed light to these questions.

### **1. Is such a whole-system change possible?**

The short answer is: yes, it is possible! However, the Basque and other successful experiences worldwide show that such transformative changes require considerable time and effort<sup>24</sup>. So, the question becomes twofold then: what is the right time span for a whole-system change? How much effort is needed?

According to Ham and Walsh, “the experience of organisations that have made the transition from fragmentation to integration demonstrates that the work is long and arduous. Leaders need to plan over an appropriate timescale (at least five years and often longer) and to base their actions on a coherent strategy”<sup>10</sup>. As international evidence shows, the successful adoption of integrated care principles into health and social care systems require “scale and pace” or “speed and spread” efforts<sup>25</sup>.

The Basque team that led the 2010 Strategy had four years to formulate and implement it, before regional elections granted power to a different political party and thus, a new regional ministerial team took over. Four years was certainly a short period to achieve all what had originally been intended, despite – as we will show below – there was a fundamental policy continuation during the subsequent phase. Interviewees have estimated that at least two legislatures (8 years) were needed to be able to roll out all the desired changes to the Basque system [interview 1; interview 11].

This is such a huge change spanning across the whole social system – not only health, but also social care, education, etc. – that requires a commitment from the whole government over a program that has to be kept over twelve years, for the health system to get transformed [interview 1].

### **2. What is the implication of focussing on transformation of healthcare delivery?**

Bringing the service delivery function at the centre of the system transformation implies designing, developing and providing services that meet the complex health and social care

needs of chronic patients. Key components of integrated care services, as reflected in the literature include: single point of entry, holistic care assessments, care planning and care coordination, through the work of case managers and multidisciplinary teams. Furthermore, the integrated care literature provides valuable thinking on how to design services that, not only respond to demand, but “proactively seek need, even when it is not voiced as demand, in the knowledge that those whose needs are greatest may be least able to access the care that they need”<sup>6</sup>.

Thus, this approach sensitizes us to rethinking the role for primary care, specialised care, public health and social services in responding to the challenge of chronicity. While the primacy of primary care and the need to coordinate specialised acute services have been widely acknowledged in the literature<sup>26-27</sup>, the linkage with public health and social care services stands as a key challenge.

The *Strategy for Tackling the Challenge of Chronicity* in the Basque Country aimed to “reinvent the health delivery model with the purpose of improving the quality of care for chronic patients, prevention of these pathologies and advancing toward a more sustainable model”<sup>5</sup>. In meeting this challenge, the Basque Strategy chose to build upon the strengths of their existing model of primary care to manage chronic conditions, while requiring specialised care to innovate as well to improve the management of patients during the acute phases of their diseases. The desired goal was to strike a new and better balance between levels of health care – a goal which was formulated in the motto “(Let’s do) more at home, more at the primary care setting, less at the hospital” [*Mas en casa, más en primaria, menos en hospital*].

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## 6.2. Leading organisational change

In his seminal book *Complex Organisations*, Charles Perrow, one of the founders of the modern discipline of Organisational Theory, argued that “all social processes either have their origin in formal organisations or are highly mediated by them”<sup>28</sup>. Thus, looking at system-wide transformations towards integrated care systems for chronic patients from an organisational theory approach sensitizes us to the fact that such transformative moves require changing organisations (i.e. transforming an entire regional health service organisation such as Osakidetza in the Basque Country; creating local micro-systems, etc).

For the purpose of this paper, the key question becomes: what forces can bring about change in large public sector organisations? A quick look at the different competing theories and accounts on how organisational change takes place helps to simplify the answer to two key forces: internal components and environmental pressures. First, instilling change from within therefore implies acting upon the internal components of any organisation: bureaucratic elements, human relations, leadership, processes of institutionalisation of practices and rules, just to mention a key few. Second, organisational changes are the result of powerful external forces such as technology, culture, economy, demographic, legal, etc.<sup>29</sup>.

Within the scope of what is possible in this paper, two key questions arising from the organisational theory perspective have been selected to analyse the Basque Strategy:

- ✓ Which type of leadership was used?
- ✓ What was the role of technology in transforming the organisation?

Osakidetza is the only public provider of health services in the Basque Country, including primary care, hospital care (both acute and long-term care), specialist outpatient clinics, emergencies and mental health". In the years prior to the launch of the Basque Strategy, Osakidetza had made progress in adopting total quality approaches, such as Total Quality Management (TQM), the European Foundation for Quality Management (EFQM) model, etc, which probably prepared the way for the transformative move that came suit. However, a new leadership approach, supported by the right technological tools was needed.

### **1. Which type of leadership is needed?**

The need to have sustained commitment and a systemic vision at the strategy level (at the most senior levels) has been widely recognized in the specialised literature<sup>30</sup> and it is one of the key messages that interviewees for this project have agreed upon: leadership with clear ideas [interview 1] and focus [interview 11]. Importantly as well, such a commitment has to be maintained even if leaders are convinced that the benefits will not be immediately seen (not even in the short time span of the 4 years of the electoral cycle), and so, their efforts would not automatically or necessarily be rewarded [interview 11].

However, together with this type of high-level leadership, successful experiences are showing that a more horizontally distributed commitment within lower organisational levels is also needed. The literature has referred to this as distributed leadership<sup>31-33</sup>.

[Distributed leadership] does not require an individual who can perform all of the essential leadership functions, only a set of people who can collectively perform them. Some leadership functions (e.g., making important decisions) may be shared by several members of a group, some leadership functions may be allocated to individual members, and a particular leadership function may be performed by different people at different times. The leadership actions of any individual leader are much less important than the collective leadership provided by members of the organisation<sup>31</sup>.

The Basque Strategy adopted a distributed style of leadership, aiming to avoid either a top-down interventionist focus nor a more development-focused bottom up style, as neither of these approaches would be able to act alone as a driver for change<sup>1</sup>. Thus, top-down interventions – including population based risk stratification, call centre, shared electronic medical records (Osabide Global), new commissioning schemes and electronic prescription - would ensure a minimum level of standardisation across the entire health system.

Alongside these, bottom-up interventions at the local level would allow the coordination and integration “in clinical terms rather than a focus on structural or managerial integration...engaging clinical and nursing leadership in the change process”<sup>4</sup>.

We (the team at the department of health) didn't want to tell providers of care what to do, because that'd be the top-down approach that we always criticise, and, anyway, we wouldn't have better knowledge than them of how to best do it. So, what can we do from above then? We can send signals of how we will, for example, start financing you as a provider, how we will measure your progress, (,,) but the how you are going to do it is up to you. There can be many “hows”. My role is to facilitate from above that you are able to implement all those “hows” [interview 8].

So, instead, bottom-up innovations were promoted and pursued, mainly through action research projects, and thus variations and local particularities were welcomed in areas such as new nursing modalities, patient empowerment, health and social care coordination, sub-acute centres and clinical integration and collaborative care. At the same time though, to encourage and harness learning from each other, various “communities of practice” were promoted from the Department of Health. The “communities of practice”<sup>34</sup> is a term related to distributed leadership and refers to social learning organisations whereby, under the internal

leadership of a community coordinator, members engage and do things together, reflect on potential improvements and develop coordinated perspectives, interpretations and actions to achieve higher<sup>35</sup>. For example, Hobe4+ was a primary care-based community of practice for innovation based on the creativity of health care staff.

## 2. What should the role of technology be?

Technology transforms human behaviour, organisations and cultures, as much as technology emanates from these. Leading large-scale organisational changes require the use of technology, in particular information and communications technologies (ICTs). However, large-scale changes can get bogged down or staled if technology investments become a goal per se, unrelated to other partial goals or without a proper framing in the wider narrative for change. In fact, new technologies can work against system-wide transformations if they come to “replicate the existing organisational model of managing one disease at a time and therefore may inadvertently reinforce the silo effect”<sup>4</sup>.

The growth of Telehealth and Telecare for chronic patients has been exponential in recent years<sup>36</sup>. Likewise, ICTs are being deployed for supporting the management of patient admission processes, waiting lists, referrals, electronic records, etc.

The Shared Electronic Health Record (Osabide Global), designed and piloted in 2010 and fully implemented by 2014 became instrumental in enabling “professionals (at all levels of care) to access and collect all relevant data concerning each patient, to guide decision making and, in general, allows them to have a comprehensive and global vision of the patient”<sup>1</sup>. In addition, a Multi-channel Health Service Centre (*Osarean*), coordinated the provision of e-health services, health advice, prescription support and non-face-to-face appointments, among other activities, using Web access and SMS technology. Furthermore, not only professionals to patient’s data at the different levels of care, but actually all Basque citizens have access to all objective clinical data contained in their own personal health record.

However, in the case of the Basque Country, some interviewees have questioned the approach to the uptake of technology, arguing that technology users were some steps behind the goals pursued by this policy: “to request an outpatient visit, you would phone a number and a machine would answer. So, old people ended up going to the primary care centre. This is because, despite the speed sought (by policy makers to instil change),

citizens need another rhythm” [interview 3]. Another interviewee thought that “the health information system was not at the level needed by the professionals. It should have been much simpler for the professional, so he can easily know who their patients at most risk are, instead of having to plunge into the e-records to find who they are. It has to be much easier” [interview 1].

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### 6.3. The governance of change

System-wide transformations affecting multiple organisations and care providers such as the move towards chronicity in the Basque country are crucially influenced by political dynamics and institutional contexts<sup>33</sup>. The policy process discipline aims to understanding the dynamics of, and influences on policy change. In a nutshell, the discipline seeks to answer the question: who gets what, when and how?

Political science frameworks and models have been developed to account for the increasing number of actors and institutions involved in any policy process in modern states. Such proliferation of actors and policy arenas is particularly visible in the health sector:

The policy process is now crowded with more and new actors such as delivery agencies, international organisations (e.g. the European Union) and new social groups such as health consumer groups, while the government is not necessarily the most powerful actor in the policy arena. Ministers and civil servants engage with other actors, exchanging resources and thus establishing stable patterns of interaction in the form of ‘policy networks’. Globalisation, Europeanization, devolution and decentralisation (to local authorities and arm’s length bodies) have opened up policy making arenas which were previously limited to the central government level<sup>37</sup>.

Recent frameworks and models have challenge traditional views of the policy process as rational, linear and sequential processes, where very often government finds itself little capable of controlling (or even dominating) the formulation and implementation of health policies<sup>38</sup>. Such new scenario for policy makers and the alternative approaches it demands has been encapsulated under the concept of governance<sup>39</sup>. It aims to describe a defining feature of modern states in which a large number of old and new actors and institutions are now involved in every policy process, therefore transforming the way we understand state-society relationships and political power.

According to the governance approach, the broad state-society changes cannot be steered with the old models of command and control, public administration or management of the past<sup>40</sup> and new approaches and tools for governing public sector organisations<sup>41</sup>. While terms are very often used inter-changeably, governance “has a broader meaning than the usual restricted business-like, market-oriented interpretation of the concept of management. Public governance is also related to legality and legitimacy, and more than strict business values...Thus, public management should be broadened into ‘public governance’, in which the external orientation at the socio-political environment plays an important part, as well as the complexity of administrative relations, and the specific character of governance in complex networks”<sup>42</sup>.

The governance lens then goes one step beyond the traditional areas of interest of management theory such as performance measurement, efficiency and quality to include new topics such as networking with external stakeholders, engaging with citizens and other stakeholders, equity, accountability, transparency, evidence-based policy and practice, etc. Quoting Bovaird and Löffler,

whereas in new public management a lot of attention was paid to the measurement of results (both individual and organisational) in terms of outputs, public governance pays a lot of attention to how different organisations interact in order to achieve a higher level of desired results - the outcomes achieved by citizens and stakeholders. Moreover, the way in which decisions are reached - the processes by which different stakeholders interact - are also seen in public governance to have a major importance in themselves, whatever the outputs or outcomes achieved<sup>40</sup>.

Questions arising from the governance literature include:

- ✓ How to muddle through conflicting interests?
- ✓ Which lever(s) to press first?

The way the Basque Strategy has been formulated and implemented reflects the changing and complex scenario which a pro-reformer government has to engage with in order to move forward a system-wide transformation of the health system towards the chronic integrated care agenda.

## 1. How to muddle through conflicting interests?

System-wide transformations towards integrated care for chronic patients is not a simple matter of skilled management but rather a humble (but focused) exercise of networking with many actors and engaging with citizens and stakeholders in a transparent and democratic manner. Pro-reformers commonly encounter great pressures against change or for change to happen in a particular way that only pursues the interest of a group.

The Basque case reflects these strong pressures as well. One key contributor to the Basque Strategy summarises the pressures and oppositions as follows:

Amidst the economic and financial crises of the time, the Strategy was, at its best, mildly received. To attempt to transform a system in the context of extreme budget cuts was seen as frivolous and by no means urgent. Terms such as integration and coordination resounded technocratic. The political opposition was very tough, achieving the alignment of senior health managers was very tricky and, among health professionals, there was a small group of enthusiasts while the rest was an expectant crowd. Broadly speaking, patient associations failed to see the opportunities that the new approach to chronicity opened to them in contrast to the old discourse of acute illness<sup>43</sup>.

Interviewees had conflicting opinions on the position of primary care staff towards policy changes. For some respondents, primary care opposed or resisted the changes [interview 1; interview 12], while hospital generalists welcomed the strategy much more enthusiastically than primary care staff, including both GPs and nurses. “Some health workers and managers from Primary Care [saw] the integration process as a loss of power within the Organisation and perceive that most of the power has shifted to the Hospital”<sup>12</sup>. Other interviewees, however, think that primary care accepted the strategy quite enthusiastically, seeing their chance to talking to hospital specialists as equals [interview 7].

Reflecting upon their reform experience, interviewees mentioned strategies to target potential opposition groups. One interviewee suggested tackling key groups of hospital specialists, mainly clinicians (pneumologists, cardiologists, internists, etc.) rather than surgical or other specialists [interview 11]. Other interviewees referred to discrepancies within the political team and opposition coming from top officials at the department of health and Osakidetza [interview 8; interview 10; interview 12]: “some members of the top team

were not on board”. Likewise, middle-level managers at hospitals and primary care centres would publicly agree while, at the end of the day, they were not genuinely on board: [interview 2; interview 9; interview 10]. One interviewee reflected: “if I were to do it again, I’d change 90% of the management teams, those who weren’t pro-active...”[interview 10]. Quoting Nuño-Solinís<sup>43</sup> even between the Health Department and Osakidetza “there was no full consensus either on the need for the Strategy nor its scope and approach. For example, while the Health Minister talked about transformation, some within his team talked about slow change”.

In any case, blocking reforms does not necessarily require actively opposing them [interview1; interview 9]:

“inertia is similarly powerful to active opposition. As long as people do not collaborate, that becomes enough to de-activate reforms” [interview 9].

In this complex scenario of multiple and conflicting interests and much distance or disengagement with reform proposals, it became extremely important to build an exciting narrative to capture the minds and hearts of people. “A clear vision from the policy makers has fostered the joining of forces and making of alliances between the various institutions and agents involved”<sup>1</sup>.

One interesting question is whether a number of stable pre-conditions should exist to make possible system-wide changes. According to one interviewee, three things need to be more or less under control before embarking on system-wide reforms: no huge financial deficits, waiting lists and relations with trade unions. Otherwise, these would force managers to focus on the day-to-day management [interview 11]. This is partly confirmed by other interviewee who points that trade unions did not oppose the reforms despite the setting up of new organisational forms (the OSIs) would potentially re-balanced power relations and lead to a loss of the trade union influence [interview 10].

## **2. Which lever(s) to press first?**

Tools to instil change have to be cleverly selected and strategically used to mobilize multiple interests in order to produce system-wide transformations. While all are necessary if change is to succeed [interview 4], most interviewees would suggest that a few tools are particularly important. But which lever or levers to press first and foremost?

Policy makers involved in formulating and implementing the Basque Strategy interviewed for this research agreed in identifying the integrated electronic health record, the stratifying the population and the facilitating of bottom-up experiences as key tools that are needed from the start. In a second group of key tools, people mentioned new funding mechanisms to use incentives cleverly, followed by the development of new staff roles (i.e. advanced nursing competencies, case managers), collaborative relationships between health professionals (mainly between primary care doctors and hospital generalist) to ensure continuity of care and the development of institutional capacity to produce and disseminate evidence.

## 7. Post-2013 developments

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The regional elections of October 2012 led to a change in the Basque government, granting power to a different political party and thus leading to the setting up of a different health department team. In December 2012, Jon Darpón replaced Rafael Bengoa as regional health minister. A new set of documents followed suit to mark the policy direction for the new legislature 2013-2016<sup>44</sup>.

All people interviewed for this research agreed that the coming of a new departmental team in December 2012 did not bring about a u-turn in health policy in the Basque country. “Continuity” has been one of the terms most used by interviewees, mentioning that most of the tools implemented during the previous period (stratification, new nursing profiles, the use of economic incentives through contract programme to promote bottom-up experiences, etc.) have remained [interview 5; interview 6].

However, they all agree that there has been a “refocusing” of priorities and “a change in rhythm”.

The current vision is that it is necessary to bring together the institutions so they can work together. The previous vision...was instead “let’s find first what we want to achieve and let’s agree to work together towards that direction”...What the previous team sought was voluntary agreements. Now it is rather agreements by zones: now, there is unified direction for both hospitals and primary [interview 1].

The issue of chronicity continues to be on the table, although one respondent argued that the fact that the last stratification process was done in 2013 shows that it has lost momentum [interview 10]. There is probably now more emphasis on integrated care. Before, integration was portrayed as a mean to tackle chronicity, while now it is an entity on its own: rather than integrating to solve the problems of people living with chronic conditions, “integrating because it is the right thing to do” [interview 6]. Likewise, the innovative financing mechanism has been slightly modified: the new programme-contract grants a variable 5% is linked to the way the organisation is pursuing integrated care and chronicity, although this has not meant real risk transfer.

Some initiatives have not continued during the new phase, including the “communities of practice”, Kronikoen Sarea, or Etorbizi. Others have evolved: for example, the Active Patient project has now become to Osasun Eskola (Health School). Arguably though, the key change has been the focus on “organisational” transformations over clinical reforms. Integrated Care Organisations between primary and specialised care is the main purpose. Much of the emphasis now is on how to scale up from the integrated care pilots of the previous stage to fully developed organisations [interview 3; interview 5]. By 2016, the 13 OSIs covering the entire territory and population of the Basque Country are fully deployed.

Some would argue that organisational integration does not necessarily bring about integration. Critics would also add that too much emphasis on structures lead to a loss of the agency perspective – integration is, at the end of the day, a result of positive human interactions, not the automatic result of organisational merging [interview 1]. Others, however, have welcomed the current attempt to systematize and harmonize bottom-up experiences, arguing that too much piloting is not always good [interview 9].

It is not the purpose of this paper to settle these discussions. At the end of the day, the opinion of one interviewee might provide a fair assessment of all contributions, who “value(d) a lot the new regional Minister’s courage to continue with the strategy of the previous legislature” [interview 5]. Indeed, courageousness is the key attribute of any reformer attempting to instil a system-wide transformation – either to make it happen or to cast it into stone!

## 8. Conclusions

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The analysis of the *Strategy to tackle the challenge of chronicity in the Basque Country* conducted in this paper reveals that system-wide changes in health and social care are definitely possible although no simple solutions or short-cuts exist. System-wide transformation require time, effort, leadership, vision and commitment, as well as a shared narrative, inclusiveness, interaction with local implementers, “muddling through” and constant learning.

System-wide transformations towards integrated care for chronic patients are not a simple matter of skilled management but rather a humble (but focused) exercise of networking with many actors and engaging with citizens and stakeholders in a transparent and democratic manner. Reforms need to be carefully crafted, nurtured and developed. Hence, they require time, commitment and sustained effort.

A powerful vision and a collectively-constructed narrative for change is also needed. Similarly to other places, such as England, Scotland or New Zealand, the Basque Strategy provides a narrative (specifically, on chronicity and chronic care), embodied in a number of mottos (i.e. “Let’s do more at home, more at the primary care setting, less at the hospital”), aimed to capture the hearts and minds of professionals and the public. Developing such vision and narrative is key to instil cultural change.

Command-and-control managerial approaches need to leave way to consensual, collaborative and “messier” decision-making processes. Transformative initiatives led from the top-down alone are doomed to fail. Instead, favourable policy environments need to be developed locally, in which bottom up initiatives are allowed and encouraged by a supportive leadership.

Such leadership has then to be exercised in a far more complex scenario of old and new actors and institutions involved in every step of the policy process, with multiple and competing interests that require much “muddling through”. As the Basque case shows, active opposition or simply, disengagement and inertia can arise from within as well, from the same policy making team who is supposed to drive the reform forward, and thus make the reform loose momentum and de-activate.

Tools to instil change have to be cleverly selected and strategically used to mobilize multiple interests in order to produce system-wide transformations. While all may be necessary, not all tools are equally important. Key levers to shake and shift the health and social care systems towards more aligning, coordination and integration to meet the needs of the people include the integrated electronic health record, the stratifying the population and the facilitating of bottom-up experiences. Not far behind, a second group of system levers include exploring new funding mechanisms to use incentives cleverly, developing new staff roles (i.e. advanced nursing competencies, case managers), and promoting collaborative relationships between health professionals (mainly between primary care doctors and hospital generalist) to ensure continuity of care.

Reforms need to be sustained upon sound evidence of what works, where and to what cost. Measuring performance, efficiency and quality of the interventions through appropriate research evidence is an absolute requisite nowadays in our contemporary societies. On the other side of the coin, such evidence allows to ensure effective transparency and accountability. In order to support the production, compilation and dissemination of such evidence, organisational capacity (through research institutes, a project management office, etc.) has to be developed.

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Arguably, with a good level of success, the *Strategy to tackle the challenge of chronicity in the Basque Country* initiated a step-change of the health system to make it fit for the purpose of responding to the growing challenge of chronicity in the Basque country. This system-wide transformation was undertaken amidst a profound economic crisis both nationally and internationally. Rather than simply relying on drastic cost-containments decisions and severe budget cuts to achieve savings<sup>45</sup>, the Basque *Strategy* aimed to respond to the incoming challenge of demography, chronicity, fragmentation and sustainability. Above and beyond a short-term crisis, the Basque Strategy aimed to tackle a far more serious, far more disruptive, long-term challenge.

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